

Patient ID: _____

HIPAA PRIVACY AUTHORIZATION FORM

1. I hereby authorize Midlands Orthopaedics, PA to use and/or disclose the protected health information described below to _____.
[Name of Individual, Address and Telephone Number]
2. Authorization for Release of Information:
 - a. Covering the period of health care from:
 _____ to _____ **OR** all past, present and future periods.
 - b. Covering the following protected health information:
 I hereby authorize the release of my complete health record.

OR
 I hereby authorize the release of my complete health record with the exception of the following information: _____.
3. This authorization shall be in force and effect until _____, at which time this authorization expires.
[Date or event]
4. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.
5. I understand that my treatment, payment, enrollment or eligibility for benefits will not be conditioned upon signing this authorization.
6. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Signature of Patient or Personal Representative

Date

Print Name of Patient or Personal Representative

Relationship to Patient